TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

www.tdlr.texas.gov

COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION INSTRUCTIONS

The application must be completed and signed by the applicant. An application is not considered complete and will not be processed until all required items have been submitted. Attachments must be submitted on separate pieces of single-sided, 8½" x 11" paper. **DOCUMENTS SUBMITTED WITH YOUR APPLICATION WILL NOT BE RETURNED. KEEP A COPY OF YOUR COMPLETED APPLICATION, ALL ATTACHMENTS, AND YOUR CHECK OR MONEY ORDER.**

1. NAME – Write your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and (Mr. is not a suffix.)
2. DATE OF BIRTH – Write your birth date. Minors age 17 but not yet 18 may be issued a contestant's license with a notarized written consent from a parent or guardian.
3. PLACE OF BIRTH – Write the city, state, and country of your place of birth.
4. GENDER - Select whether you are male or female.
5. SOCIAL SECURITY NUMBER – Write your social security number. Social security number disclosure is required by Section 231.302(c)(1) of the Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, contact the Texas Attorney General at:

   www.texasattorneygeneral.gov/child-support or call (512) 460-6000 or (800) 252-8014
6. FOREIGN NATIONAL PASSPORT NUMBER – Applicants who are foreign nationals, must provide their passport number.
7. MAILING ADDRESS – Write your current mailing address. This is the address where we will send you mail. This address can be a post office box. You can use the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
8. EMAIL ADDRESS – Write your email address. By providing my email address I authorize TDLR to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address, or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
9. PHONE NUMBER – Write a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
10. EVENT DATE – Write the date of the combative sports event you are participating in.
11. PROMOTER NAME – Write the name of the promoter of the combative sports event.
12. STATEMENT OF APPLICANT – Carefully read the statement before you date and sign your application.
13. AUTHORIZATION TO RELEASE MEDICAL RECORDS – Carefully read the consent to release medical records before you date and sign the release.
14. PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION – Parts 1 must be completed by the contestant. Part 2 must be completed by a medical doctor licensed by a state, district, or territory of the United States of America. Part 2 signed by a physician's assistant or nurse practitioner will not be accepted. A contestant's medical examination records are only valid for six months from the date of completion.
15. OPHTHALMOLOGIC MEDICAL EXAMINATION – This exam must be completed by an ophthalmologist or optometrist licensed by a state, district, or territory of the United States of America. Ophthalmologic medical examination records are only valid for six months from the date of completion.

APPLICATION INFORMATION FOR MILITARY SERVICE MEMBERS, MILITARY VETERANS, AND MILITARY SPOUSES:

The Texas Department of Licensing and Regulation recognizes the contributions of our active duty military service members, their spouses, and veterans. If you want to use one of the licensing options available to military service members, military veterans and military spouses, please complete the Military Service Member, Military Veteran or Military Spouse Supplemental Application(TDLR form MIL001) and attach it with your license application. The form is located on the TDLR website at http://www.tdlr.texas.gov/misc/militarysupplemental.pdf.

If you have additional questions about qualifications, training or experience requirements relating to occupation licensing for military service members, military veterans or military spouses please go to the TDLR Military Information web page at http://www.tdlr.texas.gov/military.htm.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

Texas Department of Licensing and Regulation
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, please visit the Texas Department of Licensing & Regulation website at https://www.tdlr.texas.gov or reach Customer Service via webform where you can submit your request for assistance and include attachments needed at https://www.tdlr.texas.gov/help or (800) 803-9202 [in state only], (512) 463-6599, Relay Texas-TDD: (800) 735-2989 or Fax: (512) 463-9468. Customer Service Representatives are available Monday through Friday 7:00 a.m. until 6:00 p.m. Central Time (excluding holidays).

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YOU MUST MEET ALL REQUIREMENTS WITHIN 12 MONTHS OF THE FILING DATE, OR THE APPLICATION WILL BE TERMINATED.

APPLICATION FEE: $20 (FEE IS NON-REFUNDABLE)

1. Name:

Last | First | Middle Name | Suffix (I, II, III, R, SR, etc.)

2. Date of Birth: Month - Day - Year

3. Place of Birth: City, State, and Country

4. Gender: ☐ Male ☐ Female

5. Social Security Number:
See instruction sheet for disclosure information

6. Foreign National Passport Number: Foreign nationals must provide their passport number

7. Mailing Address: A PO box is allowed for this address

Number, Street Name, Suite Number Apartment Number

City | State | Zip Code

8. Email Address:

Ex johndoe gmail.com See instruction sheet for disclosure information

9. Phone Number:

Area Code | Phone Number

10. Event Date: Month - Day - Year

11. Promoter Name:

12. STATEMENT OF APPLICANT

I certify that I have read and will comply with all applicable laws and rules of the Combative Sports Program including Texas Occupations Code, Chapter 51 and Chapter 2052 Combative Sports Act and the Combative Sports Administrative Rules under 16 Texas Administrative Code, Chapter 60 and Chapter 61.

I understand that providing false information on this application may result in denial of this application and or revocation of the license I am requesting and the imposition of administrative penalties.

Date Signed | Applicant Signature

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please read this entire form before signing and complete all sections.

1. I authorize the Texas Department of Licensing and Regulation to use and disclose my protected health information medical records to the appropriate governmental authorities or myself with respect to my status as a licensed contestant.

2. This authorization for release of information covers all past, present, and future medical records.

3. I authorize the release of all protected health information medical records submitted to TDLR as a part of the following

    - Professional Contestant's Medical Examination - Part 1
    - Professional Contestant's Medical Examination - Part 2
    - Ophthalmologic Medical Exam

4. I understand that the authorization to release **all** of the above-referenced protected health information records **includes** the release of information records relating to communicable diseases, *Human Immunodeficiency Virus* **HIV** or Acquired Immune Deficiency Syndrome **AIDS** .

5. This authorization shall remain in effect until the expiration of my license, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I have read this form and agree to the uses and disclosure of the health information medical records as described.

I understand that refusing to sign this form does not affect disclosures of health information medical records that have occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy law.

_____
PRINT NAME OF APPLICANT

_____
SIGNATURE OF APPLICANT

_____
DATE SIGNED

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PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 1
This form must be completed by the contestant applicant (athlete).

Legal Name (Last, First, Middle) Federal National ID

Address (Street, City, State, Country)

Telephone E-mail Date of Birth _____

Sex M F Emergency Contact Emergency Telephone

ALL SECTIONS MUST BE ANSWERED

Health History

Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Seizure, flashing lights	□	□	High blood pressure	□	□
Headaches or dizziness	□	□	Asthma or wheezing	□	□
Cerebral hemorrhage	□	□	Broken bones or recent sprains	□	□
Passed out during exercise	□	□	Neck or spine injury	□	□
Double or blurred vision	□	□	Hernia	□	□
LASIK, PRK, or other eye surgery	□	□	Cold sores, fever blisters or herpes	□	□
Retinal Detachment	□	□	Diabetes	□	□
Hearing difficulty	□	□	Bleeding problems	□	□
Broken nose	□	□	Hepatitis or liver problems	□	□
Chest pain	□	□	Heat stroke/heat exhaustion	□	□
Irregular heart beat or murmur	□	□	Recent illness or fever	□	□
Muscle cramping during exercise	□	□	Sickle cell trait or disease	□	□

If "Yes" to any of the above, explain: _____

Results of the following blood tests MUST be attached to the application:
□ Hepatitis B Surface ANTIGEN □ Hepatitis C ANTIBODY □ HIV ANTIBODY

	Yes	No	
Have you ever had a concussion, a head injury, or lost consciousness?	□	□	_____
Do you or have you ever used steroids, testosterone, or banned substances?	□	□	_____
Have you ever had any other surgeries?	□	□	_____
Do any diseases run in your family?	□	□	_____
Have you seen a doctor for *any* medical problem in the last 3 months?	□	□	_____
Do you have any other medical conditions or training/sparring injuries?	□	□	_____
Women only: Have you ever had any type of breast surgery?	□	□	_____

Are you allergic to any medications or supplements? _____

What medications or supplements are you taking on a regular basis? _____

What medications or supplements have you taken within the last two weeks? _____

Sport History

Amateur Record: _____ Pro Record: _____

Date of last bout: _____ Result: _____ Number of times knocked out: _____

Number of times knocked out in past year: _____ Date of last knock out: _____

A PERSON 36 YEARS OF AGE OR OLDER MUST SUBMIT A FAVORABLE
□ EEG (Electroencephalography) AND □ EKG (electrocardiogram)

I understand that the examining physician depends on the reliability of the statements I made above I attest that the answers given above are true and correct to the best of my knowledge and belief.

Contestant Applicant Name (printed) Signature Date

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PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 2

This form MUST be completed by LICENSED PHYSICIAN (M.D./D.O.).

Legal Name:_____
Last First Middle

Address:_____
Street City State Country

Date of Birth:_____/_____/_____ Sex: □ M □ F Federal/National ID#:_____

ALL SECTIONS MUST BE ANSWERED

PHYSICAL EXAM: This section is to be completed by the examining physician.

□ **The athlete presented a valid form of photo identification and I have personally verified his/her identity.**

Height:_____ Weight:_____ Temp:_____ RR:_____ BP:_____/_____ HR:_____

		Normal	Abnormal
General		□	□
HEENT	Head	□	□
	PERRLA/EOMI	□	□
	Periorbital Regions	□	□
	Ears/Hearing (grossly)	□	□
	Jaw/Oropharynx/Teeth	□	□
	Nose (stability, obstruction)	□	□
	Lymph Nodes	□	□
	Neck	□	□
Vision	PERRLA/EOMI	□	□
	Peripheral/Fields (grossly)	□	□
Heart	Rhythm/Sounds/Murmurs	□	□
Chest	Lungs	□	□
	Ribs	□	□

		Normal	Abnormal
Abd.	(Hernias)	□	□
	(Masses/Tenderness)	□	□
Ext.	Extremities	□	□
	Hands/Wrists	□	□
	Knuckle Push-ups	□	□
	Duck/Crab walk	□	□
Skin	(Rashes/Lacerations)	□	□
Neuro.	Alertness/Orientation	□	□
	Cranial Nerves (grossly)	□	□
	Tandem Gait	□	□
	Romberg/Pronator Drift	□	□
	Finger to Nose	□	□
	Reflexes	□	□
	Other:_____	□	□

Abnormals:_____

_____

I hereby certify that based on the statements made by the contestant applicant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that contestant applicant □ **IS** □ **IS NOT** in good physical condition and □ **IS** □ **IS NOT** medically cleared to be licensed as a contestant in a professional boxing/mixed martial arts event.

Reason if NOT cleared for competition: _____

_____ _____ _____ _____
Physician's Name, M.D./D.O. Signature License No. Date

_____ _____ _____
Office Address Phone Fax

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OPHTHALMOLOGIC MEDICAL EXAMINATION

This form must be completed by a LICENSED OPHTHALMOLOGIST or OPTOMETRIST

Legal Name: _____
Last First Middle

Date of Birth: _____/_____/_____
Month Day Year

ALL SECTIONS MUST BE ANSWERED

			Normal	Abnormal
Visual Acuity Measurement	**RIGHT EYE**	**LEFT EYE**		
Without Correction	**N**____/____	**N**____/____	☐	☐
	F____/____	**F**____/____	☐	☐
With Correction	**N**____/____	**N**____/____	☐	☐
	F____/____	**F**____/____	☐	☐
Tonometry Measurements	_____**mmHg**	_____**mmHg**	☐	☐
Exterior Exam			☐	☐
Anterior Exam			☐	☐
Fundi			☐	☐
Extraocular Muscles			☐	☐
Visual Fields (confrontation)			☐	☐

Explain Abnormal Findings: _____

_____

Diagnosis: _____

_____

Dilated exam was performed on _____ **Date of exam:** _____/_____/_____
Applicant Contestant Name Month Day Year

I APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT

Ophthalmologist or Optometrist Name (print) _____

License Number: _____

Street Address _____ City _____

State _____ Zip Code _____ Phone Number (_____) _____

Ophthalmologist or
Optometrist Signature _____ Date _____

Contestant Applicant Name _____ _____ _____
(printed) Signature Date